

ways, one would, strictly speaking, need hundreds of thousands of randomised trials to arrive at conclusive answers about the efficacy of this form of treatment. Clearly, this is not practical. The Centre for Complementary Health Studies is therefore planning a trial designed to answer the much broader question, "does homoeopathy work (regardless of remedy, dose, etc)?" I would be delighted to hear from potential participants in this multicentre study.

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1 Lökken P, Straumshøj PA, Tveiten D, Skjelbred P, Borchgrevink CF. Effect of homoeopathy on pain and other events after acute trauma: placebo controlled trial with bilateral oral surgery. *BMJ* 1994;310:1439-42. (3 June.)

Trial puts negative gloss on essentially positive results

EDITOR,—It is well known that reports of trials tend to exaggerate differences between treatments.¹ By using multiple end points, repeated measures, subgroup analyses, and statistical "data dredging" authors are often able to put a positive gloss on essentially negative results. Per Lökken and colleagues' trial of homoeopathy after dental surgery is a reversal of this trend.² Four predefined clinical outcome measures were used: pain, swelling, bleeding, and trismus. There was no difference in the first three of these measures between the groups. Homoeopathy was statistically superior to placebo for the fourth measure. Yet the authors conclude that there was "no significant effect of homoeopathy on pain and other events." One of the key messages states, "no positive evidence could be found for homoeopathic effects."

The results of the trial clearly do not validate the claim that homoeopathic remedies are of appreciable clinical value after dental surgery. But ignoring significant results is surely as much of an error as creating them by massaging data.

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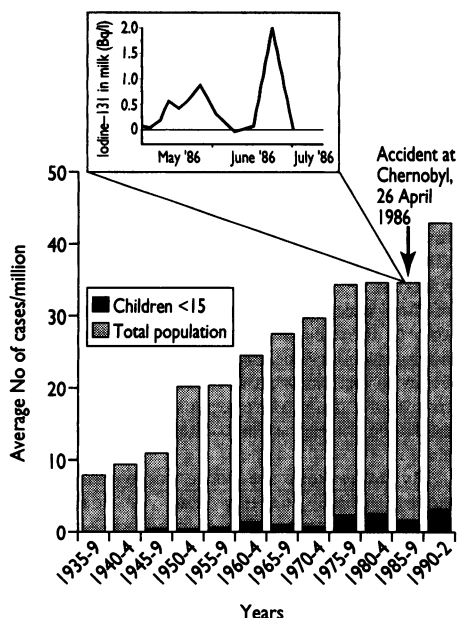
2 Lökken P, Straumshøj PA, Tveiten D, Skjelbred P, Borchgrevink CF. Effect of homoeopathy on pain and other events after acute trauma: placebo controlled trial with bilateral oral surgery. *BMJ* 1994;310:1439-42. (3 June.)

Thyroid cancer in the United States since accident at Chernobyl

EDITOR,—V A Stsiazhko and colleagues' letter on childhood thyroid cancer near Chernobyl raises serious issues on a broader scale.¹ If fallout from Chernobyl travelled hundreds of kilometres it seems reasonable that similar findings may occur in more distant populations.

Fallout from Chernobyl began arriving in Connecticut in the United States, 7250 km west of the reactor, about 15 days after the explosion which occurred on 26 April 1986. The concentration of iodine-131 (one of the few radionuclides tracked) in Connecticut's milk increased in the weeks after the accident (the state average in 1983-90 was about 0.07 Bq/l).²

The rate of thyroid cancer among children aged under 15 in Connecticut rose sharply (from 1.6 to 3.1 per million) after 1989 (figure), when increases in children in the area around Chernobyl began.^{3,4} This change is similar to that seen in the (upwind)



Number of cases of thyroid cancer per million children aged under 15 and age adjusted rate per million population in Connecticut 1935-92 (source: Connecticut tumour registry) and concentration of iodine-131 in milk in Connecticut²

Ukraine.¹ It is also intriguing to juxtapose rates of thyroid cancer for all age groups with those in children. The age adjusted rate in Connecticut between 1985-9 and 1990-2 rose from 34.6 to 42.9 per million, after 10 years of no change.

There is an apparent five year lag between exposure to radioactive fallout from Chernobyl and rising rates of thyroid cancer. In contrast, lag times have been reported to be up to 40 years for iatrogenic thyroid cancer due to irradiation.³ Continued tracking of rates may show a progressive rise in thyroid cancer attributable to fallout of a variety of (iodine and other) high energy nucleotides from Chernobyl. It seems prudent to examine further the long term effects, in particular thyroid cancer, on populations distant from Chernobyl.

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1 Stsiazhko VA, Tsyb AF, Tronko ND, Souchkevitch G, Baverstock KF. Childhood thyroid cancer since accident at Chernobyl. *BMJ* 1995;310:801. (25 March.)

2 US Environmental Protection Agency. *Environmental radiation data*. Montgomery, AL: EPA, 1986: 94-107. (Report 46.)

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4 Likhartev IA, Sobolev BG, Kairo IA, Tronko ND, Bogdanava TI, Oleinic VA, et al. Thyroid cancer in the Ukraine. *Nature* 1995;375:365.

5 Raventos A, Winship T. The latent intervals for thyroid cancer following irradiation. *Radiology* 1964;83:501-8.

Spinal cord injury in Rugby Union players

EDITOR,—Timothy Noakes and Ismail Jakoet are right in saying that there are no reliable figures for the number of spinal cord injuries sustained by rugby players.¹ The Duke of Cornwall Spinal Injuries Centre states that 16% of all spinal injuries result from sporting activities, with 2.5% being due to rugby.²

For the past 15 months I have been working as a volunteer for the Trevor Jones Tetraplegic Trust, set up to help people completely paralysed as a

result of sports injuries. The trust has the names of 140 people disabled in this way, and I have analysed details on 98 of these from the registration forms filled in by the patients or, occasionally, a relative. Fifty two of the injuries occurred while the person was playing Rugby Union football: four in the 1970s, 28 in the '80s, and 12 in the '90s. The figures are nowhere near complete: the '90s are only half run, and many of those injured are still in injuries centres.

But I find the figures worrying. There is little evidence of a reduction in the number of such lesions in Britain since the last change in Rugby Union's rules in 1985, as 22 of them were sustained after that date. These are devastating accidents for those who would otherwise have had a promising future. Of the 52 patients, 31 were 25 years old or younger at the time of injury. Only 28 list any present occupation, and 10 of these are students, who may or may not get a job. Insurance compensation is derisory compared with that received by victims of road traffic accidents, and if anyone, with enormous effort, makes a success of a job then any additional income may be clawed back by the social services. "I can't see how I shall ever get off income support," said one man, who had progressed from computer operator to information technology manager for his firm.

It is not only the epidemiology that needs study. Little information is available on the late outcome of spinal injuries: whether those who get adequate compensation fare better, what happens to the unknown number who lose touch with their unit, and how many die at an early age and of what causes. Tetraplegic people live under constant threat of pressure sores, urinary infections, and rejection by society. Rugby, I am told, is a great game; it is certainly a profitable one. But it exacts a dreadful toll from some. My 14 year old, lightly built grandson is now at a school where rugby is played, and I have asked his parents to encourage him to choose another sport. Am I overreacting?

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Training in family planning encompasses several disciplines

EDITOR,—P D Woolley seems not only to have misunderstood the editorial by Yvonne Stedman and Max Elstein¹ but to be unaware of the developments in family planning and sexual health issues.²

Basic training in family planning has been structured for many years, long before training in most other specialties, and includes knowledge of infections. Two years ago the Faculty of Family Planning and Reproductive Health Care of the Royal College of Obstetricians and Gynaecologists was founded; it has developed a membership examination (MFFP), which will start this autumn and includes genitourinary medicine in its syllabus. In contrast, doctors can and often do become consultants in genitourinary medicine without experience in family planning or gynaecology.

Family planning is rapidly becoming a consultant led specialty, often by people with broad experience and multiple qualifications, including in genitourinary medicine. As in most services, other clinicians in various grades will always be needed to help with family planning clinics, and no one thinks that family planning should encompass all genitourinary medicine.

Surely, however, family planning services should be accessible and acceptable to all who need them